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CRITICAL THINKING

Matt Morgan: Head, shoulders, knees, and toes—what’s next on the NHS waiting list?

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Even while ventilators continue to hiss and treat large numbers of inpatients with covid-19, attention has already turned to “what’s next.” The bulging NHS waiting list is an obvious place to start.

Over half a million patients in Wales are waiting for non-urgent treatment.¹ The Reform think tank predicts that 10 million people could be waiting for surgery in England by April, a sixth of the population.² The longest waits are for orthopaedic treatments that, unlike cancer, are considered non-urgent despite the pain and disability from untreated disease. Dealing with the inflated waiting lists has been described by the deputy chief medical officer for Wales as a “mammoth task.”¹ But I hope that the idea of blindly throwing more of the same resources at the problem won’t survive (much like the woolly mammoth).

I’ve needed an operation for joint pain myself, so I know how transformative surgery can be. However, I also feel strongly that all treatments should be evidence based or evidence generating. While many surgical procedures have a sound basis in evidence—especially joint replacement—many do not. Arthroscopy for degenerative knee disease, for example, may have no long term benefits over “conservative” management. And it’s time to change the term “conservative” in this scenario: this approach no longer aims to just preserve function but to improve it, without the risks, costs, and burdens of surgery. Better described as non-surgical care, it can significantly decrease pain and improve function at three months. At one to two years these improvements in pain and function remain and are equal to surgery, yet without the risks.³

I don’t want to focus only on one condition, potentially risking thousands of emails from orthopaedic surgeons. The quality of evidence behind a huge range of treatments is poor. In my own specialty of critical care medicine, only around one in 10 recommended interventions is based on the highest quality trials.⁴ Rather, my point is to consider more broadly how we approach those waiting lists. Let’s use our heads before simply continuing to treat shoulders, knees, toes, and many other conditions in the same way we always have. Let’s use this opportunity to deliver impactful, evidence based surgery alongside impactful, evidence based non-surgical treatments that may be faster, safer, and delivered at lower cost—both financial and human.

But even this approach needs investment. Investment into therapy services, weight loss programmes, exercise programmes, and society. While the flash of the knife may feel like an easier short term solution,

if we’re serious about promoting the NHS as a “health” service rather than a disease removal service, this is where time, money, and focus need to flow. It will allow us to focus on those essential surgical procedures that improve lives. And it will give the highly skilled and overworked teams delivering operative care the scope to perform important, personalised surgery rather than scrambling to the top of an ever growing waiting list that’s beyond their control.

Finally, we also have an opportunity to turn weak evidence into stronger evidence. Even if waiting list treatments are not based on high quality evidence, they can at least become evidence generating. With some hospitals enrolling over 80% of patients with covid-19 into clinical trials, a sea change is possible. Now is an ideal time to invest in large platform trials based on waiting list conditions—to help patients, surgical teams, and the healthcare system, now and in an uncertain future.

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I thank the wonderful orthopaedic teams who cared for me after I broke my hand and foot. Please don’t be cross.

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- 2 Reform. What’s next for the NHS? Feb 2021. <https://reform.uk/sites/default/files/2021-02/Reform%20Edge%20-%20What%27s%20next%20for%20the%20NHS.pdf>.
- 3 Siemieniuk RAC, Harris IA, Agoritsas T, et al. Arthroscopic surgery for degenerative knee arthritis and meniscal tears: a clinical practice guideline. *BMJ* 2017;357:j1982. doi: 10.1136/bmj.j1982 pmid: 28490431
- 4 Zhang Z, Hong Y, Liu N. Scientific evidence underlying the recommendations of critical care clinical practice guidelines: a lack of high level evidence. *Intensive Care Med* 2018;44:1189-91. doi: 10.1007/s00134-018-5142-8 pmid: 29564478